

MEMORANDUM FOR THE RECORD

Based on my review of official investigations and public records regarding this mishap as well as extensive discussions with aviation experts, I, U.S. Congressman Walter B. Jones, have concluded that the fatal factor in the crash of an MV-22 Osprey on April 8, 2000 in Marana, Arizona was the aircraft's lack of a Vortex Ring State (VRS) warning system as well as the pilots' lack of critical training regarding the extreme dangers of VRS onset in the Osprey. I also believe the Marine Corps has blamed the mishap on the pilots' drive to accomplish the mission and a combination of aircrew human factors. Lieutenant Colonel Brow and Major Gruber and their families are dishonored by the assertion that the aircrew was in any way responsible for this fatal accident. Therefore, I request that the following findings be included in all official records relating to this mishap:

1. The fatal crash of an MV-22 on April 8, 2000, in Marana, Arizona, was not a result of air crew human factors or pilot error that can be attributed to the late Lieutenant Colonel John A. Brow or the late Major Brooks S. Gruber who competently and professionally performed their duties as United States Marine Corps aviators.

2. The fatal factor in the crash of an MV-22 on April 8, 2000, was the aircraft's lack of a Vortex Ring State (VRS) warning system and the Department of the Navy's failure to provide the pilots with critical training regarding the extreme dangers of VRS onset in the MV-22.

3. Because of inadequate High Rate of Descent (HROD) and VRS developmental testing, the pilots of the MV-22 involved in the accident on April 8, 2000, were not trained or able to recognize, avoid, or recover from VRS onset in the MV-22.

4. Had adequate HROD and VRS developmental testing been conducted prior to the Operational Evaluation of April 8, 2000, and had a VRS warning system been installed in the aircraft, Lieutenant Colonel Brow and Major Gruber would have been better able to avoid or recover from VRS.

5. LtCol Brow and Maj Gruber were in formation behind another MV-22. The lead aircraft had overshot its intended approach angle and therefore steepened the approach angle. Unaware of the extreme dangers of VRS onset in the MV-22, LtCol Brow and Maj Gruber slowed their airspeed and descended even quicker, to maintain position on the lead aircraft. Twenty three seconds prior to the crash, the co-pilot of the lead aircraft stated "If you want you can take it long if you need to or you can wave it off. It's your call. You're hanging dash two out there." The lead aircraft pilot decided to continue his rapid descent at a slow forward airspeed, clearly oblivious of the extreme dangers of VRS onset in the MV-22.

6. Numerous reviews and investigations following the mishap have documented that the pilots of the mishap aircraft were not provided with the necessary and critical knowledge and training to recognize, avoid or recover from the extreme dangers of Vortex Ring State (VRS) onset in the MV-22 and the potential for sudden loss of controlled flight in the MV-22 following VRS onset.

7. After the mishap, Naval Air Systems Command (NAVAIR) called for a thorough investigative flight test program to find the boundaries of VRS, characterize its handling qualities, and establish the basis for a new flight limitation, pilot procedures, and a cockpit warning system.

8. As a result of testing following the fatal accident, a visual and aural cockpit warning system was developed to alert the aircrew when the aircraft exceeded the NATOPS flight manual's rate-of-descent limit.

9. On July 27, 2000, the Marine Corps publicly announced in a press release that a combination of "human factors" caused the April 8, 2000 crash. The press release went on to implicate the mishap aircraft pilots by stating that "deviations from the scheduled flight plan, an unexpected tailwind and the pilot's extremely rapid rate of descent into the landing zone created conditions that led to the accident." The release also stated that "although the report stops short of specifying pilot error as a cause, it notes that the pilot of the ill-fated aircraft significantly exceeded the rate of descent established by regulations for safe flight." In this Official USMC press release, Marine Corps Commandant Gen. James L. Jones is quoted as saying: "the tragedy is that these were all good Marines joined in a challenging mission. Unfortunately, the pilots' drive to accomplish that mission appears to have been the fatal factor."

10. This clearly damaging language is inaccurate, based on the fact that at the time of the crash, adequate testing of the MV-22 in the High Rate of Descent/Vortex Ring State (HROD/VRS) regime had not been conducted, the MV-22 did not have a VRS warning system, and the pilots did not have adequate knowledge and training to recognize and avoid the extreme dangers of Vortex Ring State (VRS) onset in the MV-22 and the potential for sudden loss of controlled flight in the MV-22 following VRS onset.

11. According to the Government Accountability Office (GAO), the Commander, Operational Test and Evaluation Force's V-22 Operational Evaluation (OPEVAL) report indicated that the MV-22 "Naval Air Training and Operating Procedures Standardization (NATOPS) manual lacked adequate content, accuracy, and clarity at the time of the accident. Additionally, because of incomplete developmental testing in the High Rate of Descent (HROD) regime, there was insufficient explanatory or emphatic text to warn pilots of hazards of operating in this area. The flight simulator did not replicate this loss of controlled flight regime." Also, the preliminary NATOPS manual and V-22 ground school syllabus provided insufficient guidance/warning as to high rate of descent/slow airspeed conditions and the potential consequences.

12. The Judge Advocate General Manual (JAGMAN) Investigating Officer stated that "the fact that the aircraft found itself in VRS condition with no apparent warning to the aircrew, but also departed controlled flight is particularly concerning."

13. On December 15, 2000, after a second crash of the V-22 that year, then-Secretary of Defense Bill Cohen determined that the accident history of V-22 aircraft and other testing issues required an independent, high-level review of the program. He established a Blue Ribbon Panel to review the safety of the V-22 aircraft and to recommend any proposed corrective actions.

14. This panel was briefed by the Government Accountability Office (GAO) and the contents of this brief were incorporated into a subsequent GAO report. The GAO report cited concerns about the adequacy of development tests conducted prior to the aircraft entering the operational test and evaluation phase and that completion of these tests would have provided further insights into the V-22 Vortex Ring State phenomenon. In particular, the GAO found that developmental testing was deleted, deferred or simulated in order to meet cost and schedule goals.

15. The original plan to test the flying qualities of the flight control system included various rates of descent, speeds, and weights. This testing would have provided considerable knowledge of MV-22 flight

qualities especially in areas related to the sudden loss of controlled flight following VRS onset. To meet cost and schedule targets, the actual testing conducted was less than a third of that originally planned." In addition, MV-22 pilots did not understand the optimum use of nacelle tilt to recover from VRS onset. In my opinion, this testing clearly could have prevented this tragic accident by providing the pilots the knowledge and training to either avoid or recover from VRS.

16. The GAO presentation also revealed that the JAGMAN Investigating Officer opined that the MV-22 Program Manager (PMA-275), Naval Aviation Training Systems (PMA-205) and the Contractor "needed to expedite incorporation of Vortex Ring State and Blade Stall warnings and procedures into the MV-22 NATOPS. The preliminary NATOPS manual and V-22 ground school syllabus provided insufficient guidance/warning as to high rate of descent/slow airspeed conditions and the potential consequences."

17. The GAO report also revealed that the Director, Operational Test & Evaluation (DOT&E) stated that "while the possible existence of VRS in the V-22 was known when flight limits for OPEVAL were established, the unusual attitude following entry into VRS was not expected." DOT&E goes on to say "thus, the first indication the pilot may receive that he has encountered this difficulty is when the aircraft initiated an uncommanded, uncontrollable roll."

As of this evening, I have not yet received a response to this letter. Again, I want to state that I wrote Rear Admiral Johnson on June 11 of 2009, and as of this time, I have not received a response. I am very disappointed.

I hope the Navy will follow the example of the Marine Corps and will help properly honor the sacrifices of these brave pilots who gave their lives in the service of their country.

With that, Mr. Speaker, I will ask God to continue to bless our men and women in uniform in Iraq and Afghanistan. I want to ask God, in His loving arms, to hold the families who have given a child dying for freedom in Afghanistan and Iraq, and I will ask God three times: Please, God; please, God; please, God; continue to bless America.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana (Mr. BURTON) is recognized for 5 minutes.

(Mr. BURTON of Indiana addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

THE EXPANDING POWER OF THE FEDERAL GOVERNMENT AND ITS INTRUSION INTO AMERICA'S BUSINESS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Kansas (Mr. MORAN) is recognized for 5 minutes.

Mr. MORAN of Kansas. Mr. Speaker, unfortunately, here we go again—yet another attempt to expand the power of the Federal Government and to intrude further in America's business. Just like with cap-and-trade, which was forced upon Members without

proper consideration, here comes another bill from the Energy and Commerce Committee. This time it is H.R. 2749, the Food Safety Enhancement Act of 2009.

I do believe that our Nation has the safest food supply system in the world, and I also agree that we should continue to examine that supply system to make certain that we continue to improve upon it. However, H.R. 2749 will not make us a better food safety country. Instead, it will expand the Federal bureaucracy, and it will impose unnecessary costs on a struggling ag economy. This legislation represents a dramatic shift in Federal policy that could, just like cap-and-trade, devastate agriculture.

This legislation was considered by the Energy and Commerce Committee just a couple of weeks ago. Now, just like cap-and-trade, the Democratic leadership wants to bypass the expertise of the Committee on Agriculture and bring this bill to the floor, this time under a suspension of the rules—no further consideration, no markups by other committees of jurisdiction, no amendments, just a vote.

One provision of H.R. 2749 that is of particular concern is section 103. This section would require the U.S. Food and Drug Administration to set on-farm performance standards. For the first time, we would have the Federal Government telling our farmers and ranchers how to grow crops and raise livestock.

The cultivation of crops and the production of food animals is an immensely complex endeavor involving a vast range of processes. We raise a multitude of crops and livestock in numerous regions, using various production methods. Imagine if the government is allowed to dictate how all of that is done. Chaos will ensue. Unfortunately, that is what H.R. 2749 allows.

Those who have never been on a farm will be allowed to tell a producer how to conduct his or her operations. We will not improve food safety by allowing the Food and Drug Administration to tell our farmers what to do. We will improve food safety by allowing farmers and ranchers to do something that they and their ancestors have been doing for generations.

There are other problems with this bill as well—new penalties, record-keeping requirements, traceability, registration mandates, user fees—all things that do nothing to prevent food-borne diseases and outbreaks but that do plenty to keep regulators busy and that increase costs.

I raised these concerns today in a hearing of the House Agriculture Committee, which was reviewing food safety. The witnesses representing the FDA tried to reassure the committee by telling us not to worry, that they knew what they were doing and that they would consult with the Department of Agriculture. However, the FDA has no expertise in crop and livestock production practices, and I have little

confidence that the FDA will work with the USDA.

In fact, a recent example of the FDA's unwillingness to accept the expertise of the USDA was demonstrated this week. It involved another bill, H.R. 1549, which would restrict—in fact, eliminate—the use of animal antibiotics. H.R. 1549 would institute a ban on the nontherapeutic uses of antibiotics, which is another ill-conceived concept concerning a very complex issue. Yet we learned today that no consultation by the FDA has occurred with the USDA.

In a hearing earlier this week before the House Rules Committee, the FDA suddenly shifted its course and supported this ban. No new research or scientific analysis was presented. Again, apparently no consultation with the USDA occurred. So much for collaborating with the Department of Agriculture.

Mr. Speaker, we must stop rushing legislation through Congress without careful, thoughtful and complete consideration. Congress rarely gets things right when we have ample time to properly consider policy changes, but it never makes good decisions when rushed by arbitrary timetables. H.R. 2749 needs to be referred to the Committee on Agriculture to allow for necessary improvements to this food safety bill, improvements which will actually improve the food safety of our country and will not shut down agriculture.

We do not need FDA from farm to fork.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

(Ms. KAPTUR addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

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WE NEED PATIENT-CENTERED HEALTH CARE REFORM

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Arkansas (Mr. BOOZMAN) is recognized for 5 minutes.

Mr. BOOZMAN. Mr. Speaker, I share the views of my constituents in the Third Congressional District of Arkansas that we need health care reform. I believe all Americans deserve access to quality, affordable health care; but the one-size-fits-all experiment won't give hardworking Americans, like Melissa Swaim, the peace of mind that she and her family deserve when seeking medical treatment. Melissa is all too familiar with doctors' offices. Her son requires special medical treatments every 3 months that her insurance helps pay for. She is grateful to have insurance help cut the cost of these beneficial procedures and told me if her family didn't have insurance, finding the money to cover the cost would be

very difficult. But she would rather scrape her pennies together and make sacrifices on her own to pay for her son's health care rather than have someone else decide treatment on his behalf.

We need to preserve the doctor-patient relationship that Melissa and millions of Americans have learned to depend on. This allows patients to make choices that suit their individual requirements, not Washington bureaucrats. Politicians making decisions about our health care needs is a prescription for disaster. Instead of taking away health care choices, we need to be offering more opportunities for patients.

We need patient-centered health care that allows them to get the treatments and the care that they need when they need it. The Obama prescription will deny patients treatments and make them wait to get the treatments that they are allowed to receive. Recently my mother needed to have the battery changed in her pacemaker. My mom is 88 years old. She is doing very well and is a wise and caring mother, grandmother and great-grandmother to her family. With government-run health care, after taking \$500 billion from the Medicare program to help pay for the new plan, it's not a given that she would have gotten the treatment when she needed it at the proper time. This is not the standard of care that I want; it's not the standard of care Melissa wants; and it's not the standard of care 90 percent of my constituents, who have taken my online survey about government-run health care, want.

We need a plan that reduces health care costs, expands access and increases the quality of care. Unfortunately the 1,018-page Obama proposal does not achieve these goals. We need to be asking some tough questions. We need to be asking the President, we need to be asking the authors of this plan such things as, Will this allow illegal immigrants, illegal aliens access to health care? There's nothing in the bill that says no. We need to ask about the elderly, people who in the past have enjoyed access to cataract surgery to restore their vision, access to artificial hips, artificial knees to increase their mobility in a timely fashion. Will this plan allow that sort of care to continue? Those are the things that we need to be working on, and certainly to try to cram this down the American public's throat in 2 weeks is not workable. Luckily we still have time to get this right. Let's work together and make patient care the top priority of our reform.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

(Mr. DEFAZIO addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)